

# Section N

## Glossary of terms



**Accelerated death benefit**—Provision in a life insurance policy which permits an insured who is terminally ill to collect a fixed percentage of the death benefit before dying. This may be sold with the policy or as a rider to an existing policy. The object is to use the death benefit to pay health care expenses.

**Activities of daily living (ADLs)**—Activities which include help walking, getting in and out of bed, bathing, dressing, eating, toileting and taking medicine. An insured's inability to perform specific ADLs may qualify him or her for long-term care insurance benefits.

**Actual charge**—The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare approved amount or amount approved by other insurance programs.

**Acute hospital**—A hospital which provides care for persons who have a crisis, intense or severe illness or condition which requires urgent restorative care.

**Advance beneficiary notice (ABN)**—A written notice received from physicians, providers or suppliers before furnishing a service or item to notify the beneficiary:

- That Medicare will probably deny payment for that specific service or item.
- The reason the physician, provider, or supplier expects Medicare to deny payment.
- That the beneficiary will be personally and fully responsible for payment if Medicare denies payment.

An ABN gives the beneficiary the opportunity to refuse to receive the service or item.

**Appeal (Medicare)**—Medicare beneficiaries have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher review.

**Approved charge**—The amount Medicare or other insurers will use as a basis for determining how much they will pay for a given service or piece of equipment.

**Assignment (Medicare)**—The physician or supplier who “accepts assignment” under Medicare Part B agrees to accept Medicare's approved charge as payment in full. That means that after Medicare pays 80 percent of the approved amount, a doctor who accepts assignment can bill the patient (or the patient's insurance company) for only the additional 20 percent of the approved charge.

**Attained age**—The age you have reached. Insurance companies use this term when the policy's premium will increase as you grow older. The company will show prices for your attained age.

**Beneficiary**—Any person who receives benefits of an insurance policy or plan.

**Benefit maximum**—The most a health insurance policy will pay for a specified loss or covered service. The benefit can be expressed as either:

- A length of time (for example, 60 days), or
- A dollar amount (for example, \$350 for a specific procedure or illness) or
- A percentage of the Medicare approved amount.

**Benefit period**—A benefit period begins the day you go to a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any hospital care (or skill care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

**Benefit trigger**—The event that causes insurance benefits to start being paid.

**Biological**—Substances, such as whole blood, hemophilia clotting factors, tetanus antitoxins vaccines, tumor chemotherapy agent, etc.

**Calendar year**—January 1 through December 31

**Carrier (Medicare)**—A private company that has a contract with Medicare to pay your physician and most other Medicare Part A and B bills.

**Catastrophic coverage**—Once your Medicare out-of-pocket prescription drug costs reach \$4,350, you pay a small coinsurance (like five percent) or a small co-payment for covered drug costs until the end of the calendar year.

**Carve out retirement plans**—With a carve out Medicare plan, Medicare pays first and then plan pays some of the remaining balance (e.g. PERS).

**Centers for Medicare and Medicaid Services**—A branch of the Department of Health and Human Services. The federal agency is responsible for administering the Medicare and Medicaid programs.

**Certificate holder**—The person insured under a group insurance policy (see group insurance).

**CHAND**—Comprehensive Health Association of North Dakota—Created by the 1981 Legislative Assembly to provide comprehensive health insurance to residents of the state who had been denied health insurance or who had been given restricted coverage because they had health problems or were considered to be in a high risk category.

**Charges**—Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services.

**Chronic condition**—A continuous or prolonged illness or medical condition (example: asthma, diabetes, varicose veins).

**Claim**—A bill requesting that medical services be paid by Medicare or by some other insurance company.

**Claim for payment (CMS-1490S)**—Called the Patient's Request for Medical Payment, this document is prepared by the beneficiary and submitted to the carrier for payment for covered services under Medicare Part B.

**CMS**—Centers for Medicare and Medicaid Services (federal)

**COBRA**—Consolidated Omnibus Budget Reconciliation Act - Federal law requiring that workers who end employment for specified reasons have the option of purchasing group health insurance through the employer for a limited period (usually 18 months, but sometimes 36 months). When you purchase coverage under COBRA, you must pay the full premium including the employer's share.

**Cognitive impairment**—Relates to mental ability to safely care for oneself.

**Coinsurance or copayment**—The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20 percent) of the Medicare-approved

amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare prescription drug plan, the coinsurance will vary.

**Community spouse**—The spouse of an institutionalized spouse who is not receiving Medicaid.

**Conditionally renewable**—The company agrees to continue to insure you contingent upon certain specified conditions.

**Conservatorship**—A legal procedure by which one person (the conservator) is given power over the living arrangements, property and/or finances of another person (the conservatee). Conservatorships are established with legal safeguards for the conservatee.

**Contractor (Medicare)**—A private health insurance company under contract with the Centers for Medicare and Medicaid Services (CMS) to handle claims processing for Medicare Parts A and B. In North Dakota, the contractor is Noridian Administrative Services.

**Coordination of benefits**—Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

**Copayment (coinsurance)**—A specified dollar amount or percentage of covered expenses which an insurance policy or Medicare requires a beneficiary to pay towards medical bills. Medicare has two kinds of coinsurance:

- Part A: Hospitalization coinsurance begins after the first 60 days in hospital, and the 21st through the 100th day of skilled nursing facility care.
- Medicare Part B: Medical coinsurance is 20 percent of all Medicare approved charges.

**Costs**—Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same.

**Covered services**—Services for which an insurance policy (or Medicare) will pay.

**CPT (current procedural terminology)**—A list of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on the “Request for Medicare Payment” form for claims submitted for Medicare payment (published by the American Medical Association).

**Custodial care**—Care intended primarily to meet personal needs and which could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as activities of daily living (ADLs).)

**Customary charge**—The amount that individual physicians usually or frequently charge patients for specific services in similar medical circumstances.

**Deductible**—An initial amount of medical expense for which the beneficiary is responsible before Medicare or an insurance policy will pay.

**DHHS**—Department of Health and Human Services (federal)

**Diagnostic related groups (DRGs)**—Generally for Part A claims. A Medicare term for the system used to determine the amount that Medicare reimburses hospitals for inpatient services. DRG is part of the

**Prospective Payment System.** Medicare divides categories of illnesses into group and assigns a DRG to each Medicare patient being admitted to a hospital. The hospital is reimbursed a fixed amount based on the patient's DRG code.

**Disclosure statements**—A statement required by federal law which states the extent to which a policy duplicates Medicare.

**Duplication of coverage**—Coverage of the same health services by more than one health insurance policy.

**Durable medical equipment (DME)**—Durable medical equipment is equipment which can 1) withstand repeated use, 2) is primarily and customarily used to serve a medical purpose, 3) generally not useful to a person in the absence of an illness or injury, and 4) is appropriate for use in the home.

**Duration of benefits**—Time period or maximum amount of dollars for which an insurance policy will pay benefits.

**Drug coverage**—A benefit that is available through Medicare Part D plans or group health plans. Depending on plan specifics, generally the insured will pay a deductible and/or copayment for a portion of the cost of prescription medication.

**Drug list**—A list of drugs covered by a plan. This list is also called a formulary.

**Drug tier**—Drug tiers are definable by the Prescription Drug Plan (PDP). The option of creating tiers allows plans to describe drug groups that are based on classes of drugs, and charge different prices for drugs in each tier. Use of the tier pricing structure affords PDPs additional flexibility in defining the prescription drug benefit costs.

**Elimination period**—The number of days the insured must receive covered services before the insurance policy will begin paying. This is common in long-term care, hospital or indemnity type policies (also known as a deductible period).

**End stage renal disease (ESRD)**—Medical condition in which a person's kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

**Enrollment (Medicare)**—Procedure by which eligible persons can sign up for the Medicare program and receive Medicare coverage. It is handled by the Social Security Administration through local Social Security offices for Parts A and B.

**Enrollment period**—Period during which individuals may enroll for an insurance policy, Medicare or alternatives to Medicare.

**Entrance age**—The maximum or minimum age at which a company will sell the policy.

**Excess charges (Medicare)/balance billing**—The amount that a doctor's bill exceeds the Medicare-approved charge. Federal law limits this to 115 percent above the Medicare approved amount. Some Medicare supplement policies pay part or all of the excess charge.

**Exclusion**—An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include preexisting conditions such as heart disease, diabetes or hypertension. Sometimes excluded conditions are excluded only for a defined period after coverage begins.

**Expense policy**—A long-term care expense policy pays the actual daily charge up to a maximum daily benefit.

**Experimental**—Medical treatment which is not generally accepted within the medical profession. Insurance policies often do not cover experimental procedures.

**Fee for service**—Method of charging whereby a physician or other practitioner bills for each encounter (visit) or service rendered.

**Fee schedule**—A listing of accepted charges or established allowances for specified medical, dental or other procedures or services. The fee schedule usually represents either a physician's or third party's standard or maximum charges for the listed procedures.

**Fiscal intermediary**—A private company that has a contract with Medicare to pay Part A and B claims.

**Fiscal year (FY)**—The federal government's budget (or fiscal) year runs from Oct. 1 to Sept. 30 of the following calendar year.

**Formulary**—A list of drugs covered by the plan.

**Free look**—The period during which you may reconsider the purchase of an insurance policy, cancel and get a full refund. Medicare supplement and long-term care policies have a 30-day free look.

**General enrollment period**—An annual enrollment opportunity from Jan. 1 through March 31 for anyone who did not sign up for Part B of Medicare during the initial enrollment period.

**Grace period**—A specified period after a premium payment is due on an insurance policy in which the policyholder may make such payment and during which the provisions of the policy continue, usually 30 days.

**Grievance**—A complaint about the way a Medicare health plan is giving care.

**Group insurance**—A group policy is a written contract between an insurer and a middle man, usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance stating the provisions of the coverage given to each insured individual or family.

**Guaranteed issue**—An insurance policy which will be issued to anyone, regardless of health.

**Guaranteed renewable**—The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The company cannot change benefits or increase premiums because you have made claims.

**Health and Human Services, Department of (DHHS)**—An executive department of the federal government which has the ultimate authority for the Medicare and Medicaid programs.

**Health insurance claim number (HIC)**—The unique alphanumeric Medicare entitlement number assigned to a Medicare beneficiary. The number is generally the Social Security number and will appear on the Medicare card.

**Health maintenance organization (HMO)**—An organization that provides a comprehensive range of health services (including hospitalization, preventive care, diagnosis, and nursing). HMOs require members to use specific health care services (doctors, hospitals, etc.) which belong to the HMOs network. The HMO will pay

less or nothing if members go outside the network.

**Hemodialysis**—This treatment is usually done in a dialysis facility but can be done at home with the proper training and supplies. HD uses a special filter (called a dialyzer or artificial kidney) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the filter to clean out wastes and extra fluids. Then the newly cleaned blood flows through another set of tubes and back into your body.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)**—A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

**Home health agency**—A public or private agency that specializes in providing skilled nursing services, home health aides and other therapeutic services, such as physical therapy, in the home.

**Home health aide**—A semi-skilled professional, often employed by a home health agency, who provides in-home assistance with activities of daily living.

**Home health care**—Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen and walkers), medical supplies and other services.

**Hospice**—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver. Hospice care is covered under Medicare Part A.

**Inflation protection feature**—Feature which provides for an automatic benefit increase each year (generally five percent a year for the first 10 years) in order to protect against the rising costs of long-term care insurance.

**Indemnity policy**—Type of insurance policy which pays a fixed amount per day for covered services received.

**Individual health insurance**—A written contract between an insurance company and an insured person (contrast with group health insurance).

**In-home supportive services (IHSS)**—Personal care services and nonmedical services to help functionally impaired persons of all ages with limited resources stay at home.

**Initial enrollment period (Medicare)**—The seven months surrounding a person's 65th birth month.

**Inpatient**—A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services.

**Institutional spouse**—An individual who (1) is in a swing bed, State Hospital or nursing facility and at the beginning of the institutionalization was unlikely to be in the facility for at least 30 consecutive days (even if the individual does not actually remain in the facility for 30 consecutive days), and (2) is married to a spouse who is not in a swing bed, State Hospital or nursing facility.

**Institutionalization**—Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period of time or indefinitely.

**Insured**—The individual or organization protected by an insurance policy.

**Insurer**—A company which contracts to reimburse the insured for a loss covered by an insurance policy.

**Issue age**—A term used by insurance companies meaning the age you were when you purchased the policy.

**Length of stay**—The time a patient stays in a hospital or other health facility.

**Lifetime maximum**—The maximum dollar amount that a policy will pay in the policyholder's lifetime.

**Lifetime reserve days**—In the Original Medicare Plan, a total of 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

**Limited benefit plans**—Insurance plans that generally offer low premiums for limited coverage of a specific event.

**Limiting charge**—In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care supplies who don't accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment. Can also be called an excess charge.

**Long-term care (LTC)**—The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long term care can be provided in many different settings.

**Long-term care insurance**—A policy designed to help pay the costs of long-term care. Benefits are often paid in the form of a fixed dollar amount (per day or per visit) for covered long-term care expenses and may exclude or limit certain conditions from coverage.

**Long-term care ombudsman**—The office responsible for investigating patient complaints about long-term care facilities.

**Loss**—The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

**Loss ratio**—The amount that an insurer has paid for claims (loss) compared to the amount it collected from all customers in premiums, usually shown as a percentage.

**Mammogram**—The X-ray of the breast to diagnose breast cancer.

**Medically necessary**—Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of you or your doctor.

**Medicare**—Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some persons with disabilities under 65.

**Medicaid**—A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid is applied for and determined at the local county social service office.

**Medical underwriting**—The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your state law allows it) and how much to charge you for the insurance.

**Medicare Advantage plan**—A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and B benefits. Medicare Advantage plans are HMOs, PPOs or private fee-for-service plans or MSAs. If you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plans and are not paid for under Original Medicare.

**Medicare cost plans**—Medicare cost plans are a type of HMO that contracts as a Medicare health plan. As with other HMOs, the plan only pays for services outside its service area when they are emergent or urgently needed services. However, when you are enrolled in a Medicare cost plan, if you get routine services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare plan and you will be responsible for the Original Medicare deductibles and coinsurance.

**Medicare contractor**—A private health insurance company under contract with the Centers for Medicare and Medicaid Services (CMS) to handle claims processing for Medicare Parts A and B. In North Dakota, the contractor is Noridian Administrative Services.

**Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)**—The federal act signed into law Dec. 8, 2003, by President Bush. The Act is perhaps the most significant change to Medicare since Medicare was established in 1965. The law provided the first comprehensive prescription drug benefit, as well as other changes.

**Medicare prescription drug plan**—A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through the Original Medicare plan; Medicare private fee-for-service plans that offer prescription drug coverage; and Medicare cost plans offering Medicare prescription drug coverage.

**Medicare Select**—A Medicare supplement policy which offers a lower premium if you use specific doctors, hospitals and other providers. Similar to a health maintenance organization (HMO).

**Medicare as secondary payer**—Situations where you are covered by another plan in addition to Medicare and the law requires that plan to pay first. Medicare may be secondary when you are covered by a group plan and:

- You or your spouse continue to work
- You are disabled and under 65
- You are covered by workers' compensation or similar benefits

**Medicare summary notice (MSN)**—A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid and what you must pay.

**Medicare supplemental policy (Medigap, MedSup)**—Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and copayment).

**MEDPARD**—Medicare Participating Physicians and Suppliers Directory. Directory issued by a carrier listing all physicians in that carrier's area who accept Medicare assignment.

**National Association of Insurance Commissioners (NAIC)**—An organization made up of all of the nation's state insurance departments. The NAIC writes model laws and regulations for insurance companies and state legislatures.

**No age rating**—A term used by insurance companies in which premium is the same for all customers regardless of age.

**Nonforfeiture**—An optional feature of some insurance policies (usually long-term care insurance) that provides for some benefits to be paid if certain conditions have been met and the policy is lapsed.

**Non-formulary drugs**—Drugs not on a plan-approved drug list.

**Non-participating facility or physician**—Health care facility which does not participate in the Medicare program.

**Notice of non-coverage (Medicare)**—Notice from a hospital that a Medicare patient no longer requires inpatient hospital care. Medicare beneficiaries can appeal through an expedited appeal to the peer review organization (QIO) or through the usual Medicare Part A appeals procedure.

**Nursing home**—A place where persons reside who need medical or personal assistance. A nursing home can provide up to three levels of care: skilled, intermediate, and custodial. Not all nursing homes are Medicare approved/certified facilities.

**Observation status**—A status where a patient is located in the hospital, but because of the observation and diagnostic nature of their visit, not all procedures or items are covered under Part A.

**Occupational therapy**—Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

**Older Americans Act (OAA)**—Federal legislation enacted in 1965 to provide money for programs and direction for a multitude of services designed to enrich the lives of senior citizens (for example, adequate housing, income, employment, nutrition and health care).

**Ombudsman**—A citizens' representative who protects a person's rights through advocacy, providing information and encouraging institutions or agencies to respect citizens' rights.

**Open enrollment (HMO)**—A period when new subscribers may elect to enroll in a health insurance plan or HMO.

- During open enrollment the HMO cannot reject applications because of bad health.
- You are not eligible for open enrollment as long as you are eligible to be covered by an employer's health plan.

**Open enrollment (Medicare Supplement)**—The six-month period during which a new Medicare beneficiary can buy Medicare supplement insurance regardless of health problems.

- Open enrollment begins when a person 65 or over signs up for Medicare Part B.
- During your six-month long open enrollment period, an insurance company must sell you any coverage it offers, regardless of your health.

- After open enrollment, the company can reject your application because of your health or age.

**Original Medicare plan**—A health plan that lets you go to any doctor, hospital or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount and you pay your share (coinsurance). In some cases, you may be charged more than the Medicare-approved amount (i.e. excess charge). The Original Medicare plan has two parts: Part A (hospital insurance) and Part B (medical insurance).

**Osteopath**—Osteopathic medicine is a complete system of health care with a philosophy that combines the current needs of the patient and medicines available. Doctors using this approach consider both the physical and mental needs of the patient (whole person approach).

**Out-of-pocket expenses**—Costs borne directly by the patient without benefit of insurance; direct costs.

**Outlier case (Medicare)**—An unusual medical situation which requires longer hospital stays or higher treatment costs than Medicare would ordinarily cover. Once Medicare has ruled that it is an outlier case, Medicare will pay the expenses.

**Outpatient**—A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in organized programs, such as outpatient clinics.

**Participating facility or physician**—Health care provider which participates in the Medicare program and accepts Medicare payment for services. The participating provider accepts the Medicare-approved amount as payment in full. (NOTE: The patient must still pay copayments and deductibles if not covered by insurance.)

**Participating physicians/supplier agreement**—An agreement, by an individual physician or supplier, to accept the Medicare approved amount as payment in full for all Medicare beneficiaries served. This agreement is valid for the calendar year and may be renewed annually.

**Peer review organization (PRO)**—Organization paid by the federal government to review hospital treatment of Medicare patients. A patient has the right to appeal to a PRO if there is a question about care or length of stay. In North Dakota, this agency is the quality improvement organization, North Dakota Healthcare Review.

**Penalty**—An amount added to your monthly premium for Medicare Part B or for a Medicare prescription drug plan if you don't join when you're first able to. You pay this higher amount as long as you have Medicare. There are some exceptions.

**Personal care**—Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming or personal hygiene. These services are not routinely paid for by either Medicare or Medicaid, but for those who qualify may be paid for by in-home supportive services (IHSS).

**Personal comfort items**—For inpatients in a hospital, such items as a television, telephone, etc.

**Physical therapy**—Services provided by specially trained and licensed physical therapists in order to relieve pain, restore maximum function, and prevent disability, injury, or loss of body part.

**Power of attorney**—A legal document which gives a person (usually a spouse, other relative or friend) the power to act on behalf of another. The person giving the power must be competent and does not lose the legal right to act on his own behalf.

**Preexisting condition**—Health conditions or problems that existed before health insurance was purchased. The definition and waiting period before these conditions are covered vary from policy to policy.

- Medicare supplement policies define “pre-existing” as a condition for which you received medical advice or treatment in the six months before you bought the policy.
- Some insurance policies (including many long-term care policies) do not cover any condition which was “in existence” during the previous 6-12 months, even if you were not aware of it or were not treated for it.

**Preferred provider organization (PPO)**—A type of Medicare Advantage plan in which you pay less if you use doctors, hospitals and providers that belong to the network. You can use doctors, hospitals and providers outside the network for an additional cost.

**Precertification (prior authorization)**—A requirement that you obtain the insurance company’s approval before a medical service is provided. If you fail to follow the precertification procedures, the company may reduce or deny claim payment.

**Premium**—Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder for insurance coverage.

**Preventive services**—Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots and screening mammograms).

**Primary payer**—Insurer that pays first when a person is covered by more than one insurance plan.

**Private fee-for-service plan**—A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan’s payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn’t cover.

**Programs of all-inclusive care for the elderly (PACE)**—PACE combines medical, social and long-term care services for frail people to help people stay independent and living in their community as long as possible, while getting the high-quality care they need. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must:

- Be 55 or older
- Live in the service area of the PACE program
- Be certified as eligible for nursing home care by the appropriate state agency
- Be able to live safely in the community

**Prospective payment system (PPS)**—Medicare’s standardized payment system developed to help control health care costs. The PPS is supposed to discourage hospitals from providing unnecessary care. Medicare pays fixed amounts based on the principal diagnosis for each Medicare hospital stay.

**Provider**—Someone who provides medical services or supplies, such as a physician, hospital, X-ray company, home health agency or pharmacy.

**Qualified Medicare beneficiaries (QMBs)**—A state program that uses Medicaid money to pay the Medicare deductibles, insurance, and the Medicare Part B premium for persons whose income and assets are low enough to qualify. Persons who believe they may be eligible should contact their local county Social Service Office.

**Quality improvement organization**—Groups of practicing doctors and other health care experts. They are

paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans and ambulatory surgical centers. This organization in North Dakota is the North Dakota Healthcare Review.

**Railroad Retirement System**—Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare).

**Reasonable and necessary care**—The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

**Reconsideration (Medicare)**—The second step in the Medicare appeal process.

**Redetermination**—The first step in the Medicare appeals process.

**Replacement notice**—Form that agent/company and buyer must sign when switching from one Medicare supplement policy to another. Protects consumers against frivolous policy switching.

**Respite care**—Services designed to provide temporary relief to a home caregiver. Example: Mrs. Jones has been taking care of her sick husband. She needs a break! An insurance policy (long-term care) with respite care could cover the cost of a temporary substitute.

**Review by MAC (Medicare)**—The third step in the Medicare appeal process.

**Rider**—A legal document which modifies an insurance policy. Riders may either extend or decrease benefits or add or exclude specific conditions.

**Second opinion**—This is when another doctor gives his or her view about what you have and how it should be treated.

**Secondary payer**—Only applies when a person is covered by more than one health plan. The secondary payer is the plan whose payments cannot be made until another plan (the primary payer) has processed the claim.

**Self-insured plan**—An organization (usually an employer) which provides group health benefits which are not covered by an insurance company. Many large employers are self-insured. The organization must pay all health claims from its own funds.

**Significant break in coverage**—Generally, a significant break in coverage is a period of 63 consecutive days during which an individual has no creditable coverage.

**Skilled nursing care**—Care which can only be provided by or under the supervision of licensed nursing personnel.

**Skilled nursing facility**—A Medicare-approved skilled nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services, and other important related health services for which Medicare pays benefits.

**Social Security Administration (SSA)**—A branch of the Department of Health and Human Services. This federal agency is responsible for the Medicare eligibility and enrollment process.

**Special election period**—A set time that a beneficiary can change health plans or return to the Original Medicare plan, such as: you move outside the service area, the organization does not renew its contract with CMS or other exceptional conditions determined by CMS. The special election period is different from the special enrollment period (SEP).

**Special enrollment period**—A set time when you can sign up for Medicare Part B and D if you didn't take Medicare Part B or D during the initial enrollment period, because you or your spouse were working and had group health plan coverage through the employer or union.

**Specific disease policy**—Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

**Specified low-income Medicare beneficiaries (SLMB)**—A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income and limited resources. People who believe they are eligible should contact their local county social service office.

**Speech therapy**—The study, examination, and treatment of defects and diseases of the voice, speech, spoken and written language.

**Spend down (Medicaid)**—Process by which a person becomes eligible for Medicaid by spending most of their income and assets—for example, through paying nursing home bills.

**Spousal impoverishment (Medicaid)**—The community property and assets of a married nursing home patient may be divided according to CMS standards to protect the property and assets of the spouse.

**Stacking**—Unscrupulous insurance sales practice. Selling two or more health insurance policies to a person when one is adequate. Stacking is illegal when selling Medicare supplement insurance.

**Standardization of Medicare Supplement**—Beginning in 1992, Medicare supplement policies must be identical to one of 12 standard plans.

**State Children's Health Insurance Program**—Free or low-cost health insurance is available in North Dakota for uninsured children under age 19. State children's health insurance programs help reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Information on your state's program is available through Insure Kids Now at 1-877-KIDS-NOW (1-877-543-7669). You can also look at [www.insurekidsnow.gov](http://www.insurekidsnow.gov) for more information.

**State Health Insurance Assistance Program (SHIP)**—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

**Suitability**—Obligation of an insurance agent to sell policies to consumers which are appropriate purchases given the circumstances of the purchaser.

**Supplemental Security Income (SSI)**—A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is or blind or determined disabled by the Social Security standards can have a basic monthly income. Eligibility is based on income and assets.

**Suppliers**—Persons or organizations, other than physicians or health care facilities, that furnish medical equipment or services, such as ambulance firms, laboratories, and equipment rental outlets.

**Swing beds**—Rural hospitals with fewer than 99 beds may enter into swing bed agreements which allow them to use beds for either acute (hospital) or long-term (skilled nursing) care beds depending on the patient’s needs.

**Tiers**—To have lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form their tiers in different ways. Here is an example of how a plan might form its tiers.

Example: Tier 1: Generic drugs. Tier 1 drugs will cost you the least amount.

Tier 2: Preferred brand-name drugs. Tier 2 drugs will cost you more than Tier 1 drugs.

Tier 3: Non-preferred brand-name drugs; Tier 3 drugs will cost you more than Tier 1 and Tier 2 drugs.

**Title XVIII**—That portion of the Social Security Act which clearly defines the provisions of Medicare.

**Title XIX**—That portion of the Social Security Act which clearly defines the provisions of Medicaid.

**Tricare**—A regionally-managed healthcare program for active duty and retired members of the uniformed services, their families and survivors.

**Tricare for Life (TFL)**—Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 and older, their eligible family members and survivors and certain former spouses.

**Unassigned claim**—A claim on which the doctor or supplier refuses to accept Medicare’s approved charge.

**Underwriting**—The process by which an insurer establishes and assumes risks according to insurability.

Example: An insurance company is “underwriting” when it agrees to insure you because you are healthy or rejects your application because you have a history of heart attacks.

**Usual, customary and reasonable charge (UCR)**—In insurance language this is the amount the company has determined to be appropriate for a particular medical service. Each company develops its own UCR. A company’s UCR is often less than doctors actually charge.

**Utilization Review Committee**—Committee in a health care facility which evaluates the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. This includes a current and retroactive review of the appropriateness of admissions, services ordered and provided, length of stay and discharge practices.

**VA**—Veterans’ Administration (federal)

**Visit**—An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional’s usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient’s home. Doctors’ services can be covered in any of these settings under Medicare.

**Waiting period**—The period of time that must pass after becoming insured before the policy will begin to pay benefits for a preexisting condition or certain specified illness.

**Waiver of liability**—Occurs when Medicare denies coverage of a Medicare benefit and the beneficiary did not know and did not have reason to know that Medicare would deny the coverage.

**Waiver of premium**—A potential feature of a long-term care insurance plan. Premium payments are not required when the beneficiary is confined and receiving benefits. The policy/certificate will indicate when the waiver will begin. The waiver ends when confinement ends.

**Workers compensation**—Insurance that employers are required to have to cover employees who get sick or injured on the job.

# Acronyms

**ADL**—Activities of daily living  
**CHAND**—Comprehensive Health Association of North Dakota  
**CMS**—Centers for Medicare and Medicaid Services  
**COBRA**—Consolidated Omnibus Budget Reconciliation Act  
**CPT**—Current procedural terminology  
**DHHS**—Department of Health and Human Services  
**DMERC**—Durable medical equipment regional carrier  
**DRG**—Diagnostic related group  
**DME**—Durable medical equipment  
**ESRD**—End stage renal disease  
**FI**—Fiscal intermediary  
**FY**—Fiscal year  
**HIC**—Health insurance claim  
**HIPAA**—Health Insurance Portability and Accountability Act of 1996  
**HMO**—Health maintenance organization  
**ICF**—Intermediate care facility  
**IHSS**—In-home supportive services  
**LCD**—Local coverage determination  
**LTC**—Long-term care insurance  
**MA**—Medicare Advantage  
**MA-PD**—Medicare Advantage Prescription Drug Plan, a Medicare Advantage plan with prescription drug coverage.  
**MEDPARD**—Medicare Participating Physicians and Supplier Directory  
**MEDSUP**—Medicare Supplement insurance  
**MMA**—Medicare Modernization Act  
**MSN**—Medicare summary notice  
**NAIC**—National Association of Insurance Commissioners  
**NCD**—National coverage determination  
**OAA**—Older American Act  
**PFFS**—Private fee for service  
**PDP**—Prescription drug plan, a private insurance with drug coverage approved by Medicare and available to Medicare beneficiaries  
**PPO**—Preferred provider organization  
**PPS**—Prospective payment system  
**QIO**—Quality improvement organization (formerly PRO)  
**QMB**—Qualified Medicare beneficiary  
**SHIC**—State Health Insurance Counseling Program  
**SLMB**—Special low-income Medicare beneficiary  
**SNAP**—Nutrition assistance programs  
**SNF**—Skilled nursing facility  
**SPED**—Service payments for the elderly and disabled  
**SSA**—Social Security Administration  
**SSN**—Social Security number  
**SSI**—Supplemental security income  
**TANF**—Temporary assistance for needy families  
**TBI**—Traumatic brain injured waiver  
**UCR**—Usual, customary and reasonable